

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G549	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/07/2013
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NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 330 E COLUMBIA LOGANSPORT, IN 46947
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W000000	<p>This visit was for the investigation of complaint #IN00131651.</p> <p>Complaint #IN00131651: SUBSTANTIATED, Federal and State deficiencies related to the allegation are cited at W149, W153, and W193.</p> <p>Dates of Survey: September 26, 27, 30, October 1, 2, and 7, 2013.</p> <p>PROVIDER NUMBER: 15G549 AIM NUMBER: 100245450 FACILITY NUMBER: 001063</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>The following deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/18/13 by Ruth Shackelford, QIDP.</p>	W000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, for 1 of 5 BDDS (Bureau of Developmental Disabilities Services) reports reviewed (client A), the facility neglected to implement their policy and procedure to immediately report an allegation of mistreatment to BDDS and to the administrator in accordance with state law and the facility neglected to supervise client A according to his identified need during inclement weather.</p> <p>Findings include:</p> <p>On 9/26/13 at 11:00am, the facility's BDDS Reports and investigations were reviewed from 06/1/13 through 09/26/13. -A 6/25/13 BDDS report for an incident on 6/12/13 at 10:45pm, indicated "on 6/24/13 at 4pm, it was reported to the [Residential Manager RM]...that on 6/12/13 at 10:45pm, [client A] was held down during a tornado siren going off in town. It was also reported that [client A] had bruise on his left (arm) under (his) arm and scrapes on his knees that came from falling after staff released [client A]." The report indicated the staff person was suspended on 6/24/13.</p>	W000149	<p>Staff were retrained on reporting procedures on 07/23/2013 at a house meeting. (Attachment 1) Staff were retrained on Client's self management plan by QDP on 10/22/2013. (Attachment 2, and 5)</p> <p>Staff will be monitored through observation by RM, QDP, and Coordinator to determine competency on an ongoing basis. (Attachment 3)</p>	10/22/2013			

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	<p>-A 7/3/13 follow up BDDS report indicated the result of the investigation indicated client A fell as the result of being released from a hold. The report indicated there was a weather emergency at the time of the incident and that a "bear hug" hold was used for the safety of the client. Staff were disciplined for failure to report the restraint and injuries to client A.</p> <p>On 10/1/13 at 1pm, a review of the facility's investigations was conducted with the Site Director (SD). The 6/24/13 investigation summary indicated the following:</p> <p>-GHS (Group Home Staff) #3 notified the RM that she "heard about" an incident reported by GHS #1 to GHS #3 which GHS #3 was not sure was reported regarding client A. GHS #3 reported "staff had noticed (a) big bruise under [client A's] arm and scrapes and bruises on his knees." GHS #1 stated to GHS #3 that "[Client A] had a behavior and [GHS #2] held him down in the hallway. [Client A] was hollering stop it, stop it. [Client A] got loose and ran to the kitchen banging around and ran back to the bathroom and tripped and fell and just laid and cried in the bathroom. When asked why she did not contact the RM or coordinator [GHS #1] stated because [GHS #2] was intimidating them and</p>						

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	<p>standing over her while writing the progress notes telling her what to write."</p> <p>-GHS #4 indicated she was on duty at the time of the incident. GHS #4 indicated the television alert warning activated for a tornado warning. She indicated the staff "got all the consumers up and then things quieted down" and the clients/consumers went back to bed. "A little while later, [GHS #2] came in early for her shift and stated the sirens are going off again so we need to get them up. [GHS #2] went into [client A's] room. [Client A] was mad that he had to get up and he was having a behavior. [GHS #2] bear hugged him and wouldn't let him go. [Client A] yelled stop. At that time, [GHS #5] told [GHS #2] to let [client A] go and [GHS #2] did." The investigation report indicated client A "ran" to the kitchen and "[GHS #2] then grabbed [client A] again and he started biting his hands. [GHS #5] told [GHS #2] again to let him go and when she did [client A] began falling toward the bathroom while [GHS #2] was still holding him." The report indicated client A fell into the door and then into the bathroom. "When asked where she thought the bruises came from [GHS #4] stated that she thought it was from where [GHS #2] grabbed [client A]. When asked why she did not report this on the night it happened [GHS #4] stated I was not sure</p>			

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	<p>what to do."</p> <p>-GHS #5 indicated she "walked over in the middle of this incident and saw [GHS #2] holding [client A]. [GHS #5] told [GHS #2] to let him go and she did. [Client A] went in (the) kitchen and got some water. When he went back into the living room, [GHS #2] again grabbed him to get him into the hallway due to the sirens. At this time, he began hitting another consumer (unidentified client) in the head. [GHS #5] again told [GHS #2] to let [client A] go and she did. [GHS #2] was trying to make [client A] stay in the hallway. When asked why she did not report this on the night it happened [GHS #5] stated I don't know."</p> <p>-GHS #2 indicated "she came in early because of the weather. She said the sirens were going off and she was helping get everyone up and in the hallway. She said [client A] went ballistic. He was biting himself and didn't want to sit so she helped him...He never sat in the hallway... [GHS #2] (indicated) [client A] threw himself into the bathroom. She stated that was how he got the scrapes because he fell into the bathtub. When asked if she put him in a bear hug, [GHS #2] stated no she did not. [GHS #2] (indicated) she tried to escort him to the hallway by holding his wrist and when he pulled</p>						

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	<p>away, she let him go. [GHS #2] stated that [GHS #5] never told her not to do what she was doing. [GHS #2] stated that it was an emergency situation and she was trying to make sure everyone was safe. When asked why she did not report [client A's] fall, [GHS #2] stated I didn't think about it."</p> <p>Client A's record was reviewed on 9/26/13 at 8:25 AM. Client A's 9/10/13 ISP (Individual Support Plan) and 9/2013 Self Management Plan (SMP) both indicated client A was non verbal, had manic behavior and required direct supervision by facility staff. Client A's SMP indicated client A's "Functional Analysis...I will become manic and begin spinning in circles and/or biting my hands. I will also run and scream through the home. I also become agitated and will act out as previously stated if I am asked to complete a task that I do not want to do (such as:) fire drills...I have become increasingly more difficult to redirect...C. Anxious or Manic: If I become anxious or manic I begin pacing, flicking my fingers, and/or become self abusive in the form of biting...To help prevent these occurrences staff should always inform me of where we are going, and what we will do when we get there. If I begin to behave manically, staff should tell me 'no' in a firm calm voice while signing No. If</p>						

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	<p>I am biting or scratching myself staff should intervene to stop the self abuse to prevent me from injuring myself. Then I should be redirected to another place...offer a new activity." Client A's SMP did not include physical restraints.</p> <p>On 9/26/13 at 11:30 AM, a review was completed of the 10/2005 "Bureau of Developmental Disability Services Policy and Guidelines." The BDDS policy and procedure indicated "...Abuse, Neglect, and Mistreatment of Individuals...it is the policy of the company to ensure that individuals are not subjected to physical, verbal, sexual, or psychological abuse by anyone including but not limited to: facility staff...other individuals, or themselves." The policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual."</p> <p>On 10/1/13 at 1:10pm, the facility's 7/2012 "Incident/Abuse/Neglect Policy" was reviewed. The policy indicated "Cardinal Services Inc. is committed to ensuring the safety, dignity, and protection of persons served. To ensure that physical, mental, sexual abuse, neglect, or exploitation of persons served</p>			

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	<p>by staff members, other persons served, or others will not be tolerated (sic); incidents will be reported and thoroughly investigated as outlined in this policy...Reportable Incidents...1.13 Injuries of unknown origin where the injury could be indicative of abuse, neglect, or exploitation or requires medical evaluation or treatment...All injuries of unknown origin and allegations of abuse, neglect, and mistreatment must be reported to the administrator immediately."</p> <p>On 10/1/13 at 1:15pm, an interview with the Director of Residential Services (DRS) was conducted. The DRS indicated staff #2 was suspended on 6/24/13 after the agency leadership became aware of the allegation. The DRS indicated GHS #2 continued to work at the group home where client A lived from 6/12/13 through 6/24/13. The DRS indicated GHS #2 was the overnight staff and was the single staff on duty from 6/12/13 through 6/24/13 for the overnight period. The DRS stated facility "staff neglected to immediately report" client A's allegation and "neglected to report" client A's injuries. The DRS indicated client A's injuries were the result of the fall during the unauthorized restraint. The DRS stated the facility "staff neglected to supervise" client A according to his</p>			

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	<p>identified behavioral need. The DRS indicated the staff failed to follow the abuse/neglect policy and procedure. The DRS indicated the night of 6/12/13 had tornado sirens sounding on and off multiple times. The DRS indicated restraining clients during the tornado warning was not part of the tornado policy and procedure for what staff were to do in the event of an emergency.</p> <p>This federal tag relates to complaint #IN00131651.</p> <p>9-3-2(a)</p>			

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview, for 1 of 5 BDDS (Bureau of Developmental Disabilities Services) reports reviewed, the facility failed to immediately report an allegation of mistreatment to BDDS and to the administrator in accordance with State Law.</p> <p>Findings include:</p> <p>On 9/26/13 at 11:00am, the facility's BDDS Reports and investigations were reviewed from 06/1/13 through 09/26/13. -A 6/25/13 BDDS report for an incident on 6/12/13 at 10:45pm, indicated "on 6/24/13 at 4pm, it was reported to the [Residential Manager RM]...that on 6/12/13 at 10:45pm, [client A] was held down during a tornado siren going off in town...[client A] had bruise on his left (arm) under (his) arm and scrapes on his knees."</p> <p>On 10/1/13 at 1pm, a review of the facility's investigations was conducted with the Site Director (SD). The 6/24/13 investigation summary indicated the</p>	W000153	Staff were retrained on reporting procedures on 07/23/2013. (Attachment 1) Staff will be monitored for competency through observations by QDP, RM, and Coordinator on an ongoing basis. (Attachment 3)	10/22/2013	

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	<p>following:</p> <p>-GHS (Group Home Staff) #3 notified the RM that she "heard about" an incident reported by GHS #1 to GHS #3 which GHS #3 was not sure was reported regarding client A. GHS #3 reported "staff had noticed (a) big bruise under [client A's] arm and scrapes and bruises on his knees." GHS #1 stated to GHS #3 that "[Client A] had a behavior and [GHS #2] held him down in the hallway. [Client A] was hollering stop it, stop it. [Client A] got loose and ran to the kitchen banging around and ran back to the bathroom and tripped and fell and just laid and cried in the bathroom. When asked why she did not contact the RM or coordinator [GHS #1] stated because [GHS #2] was intimidating them and standing over her while writing the progress notes telling her what to write."</p> <p>-GHS #4 indicated she was on duty at the time of the incident. GHS #4 indicated "A little while later, [GHS #2] came in early for her shift and stated the sirens are going off again so we need to get them up. [GHS #2] went into [client A's] room. [Client A] was mad that he had to get up and he was having a behavior. [GHS #2] bear hugged him and wouldn't let him go. [Client A] yelled stop. At that time, [GHS #5] told [GHS #2] to let [client A] go and [GHS #2] did." The</p>			

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	<p>investigation report indicated client A "ran" to the kitchen and "[GHS #2] then grabbed [client A] again and he started biting his hands. [GHS #5] told [GHS #2] again to let him go and when she did [client A] began falling toward the bathroom while [GHS #2] was still holding him." The report indicated client A fell into the door and then into the bathroom. "When asked where she thought the bruises came from [GHS #4] stated that she thought it was from where [GHS #2] grabbed [client A]. When asked why she did not report this on the night it happened [GHS #4] stated I was not sure what to do."</p> <p>-GHS #5 indicated she "walked over in the middle of this incident and saw [GHS #2] holding [client A]. [GHS #5] told [GHS #2] to let him go and she did...When [client A] went back into the living room, [GHS #2] again grabbed him to get him into the hallway due to the sirens. At this time, he began hitting another consumer (unidentified client) in the head. [GHS #5] again told [GHS #2] to let [client A] go and she did. [GHS #2] was trying to make [client A] stay in the hallway. When asked why she did not report this on the night it happened [GHS #5] stated I don't know."</p> <p>-GHS #2 indicated "she came in early</p>			

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	<p>because of the weather...She said [client A] went ballistic. He was biting himself and didn't want to sit so she helped him...He never sat in the hallway...[GHS #2] (indicated) [client A] threw himself into the bathroom. She stated that was how he got the scrapes because he fell into the bathtub. When asked if she put him in a bear hug, [GHS #2] stated no she did not. [GHS #2] (indicated) she tried to escort him to the hallway by holding his wrist and when he pulled away, she let him go. [GHS #2] stated that [GHS #5] never told her not to do what she was doing. [GHS #2] stated that it was an emergency situation and she was trying to make sure everyone was safe. When asked why she did not report [client A's] fall, [GHS #2] stated I didn't think about it."</p> <p>On 10/1/13 at 1:15pm, an interview with the Director of Residential Services (DRS) was conducted. The DRS indicated facility staff failed to immediately report client A's allegation of mistreatment and failed to report client A's injuries from the fall during the unauthorized restraint.</p> <p>This federal tag relates to complaint #IN00131651.</p> <p>9-3-2(a)</p>			

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W000193	<p>483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. Based on record review and interview, for 1 of 3 sample clients (client A), the facility failed to ensure staff who worked with clients received client specific training and retraining related to emergency procedures and client A's SMP (Self Management Plan).</p> <p>Findings include:</p> <p>On 9/26/13 at 11:00am, the facility's BDDS Reports and investigations were reviewed from 06/1/13 through 09/26/13. -A 6/25/13 BDDS report for an incident on 6/12/13 at 10:45pm, indicated "on 6/24/13 at 4pm, it was reported to the [Residential Manager RM]...that on 6/12/13 at 10:45pm, [client A] was held down during a tornado siren going off in town. It was also reported that [client A] had bruise on his left (arm) under (his) arm and scrapes on his knees that came from falling after staff released [client A]."</p> <p>-A 7/3/13 follow up BDDS report indicated the result of the investigation indicated client A fell as the result of being released from a hold. The report</p>	W000193	<p>QDP retained on Self Management Plan for client on 10/22/2013(Attachment 2 and 5)</p> <p>RM trained on Self Management Policy for emergency situations on 10/22/2013.(Attachment 2, and 4).</p> <p>Staff will be monitored through observation to determine competency by RM, QDP, and Coordinator on an ongoing basis. (Attachment 3)</p>	10/22/2013	

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	<p>indicated there was a weather emergency at the time of the incident and that a "bear hug" hold was used for the safety of the client.</p> <p>On 10/1/13 at 1pm, a review of the facility's investigations was conducted with the Site Director (SD). The 6/24/13 investigation summary indicated the following:</p> <p>-GHS (Group Home Staff) #3 notified the RM that she "heard about" an incident reported by GHS #1 to GHS #3 which GHS #3 was not sure was reported regarding client A. GHS #3 reported "staff had noticed (a) big bruise under [client A's] arm and scrapes and bruises on his knees." GHS #1 stated to GHS #3 that "[Client A] had a behavior and [GHS #2] held him down in the hallway. [Client A] was hollering stop it, stop it. [Client A] got loose and ran to the kitchen banging around and ran back to the bathroom and tripped and fell and just laid and cried in the bathroom."</p> <p>-GHS #4 indicated she was on duty at the time of the incident. GHS #4 indicated the television alert warning activated for a tornado warning. She indicated the staff "got all the consumers up and then things quieted down" and the clients/consumers went back to bed. "A little while later, [GHS #2] came in early for her shift and</p>			

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	<p>stated the sirens are going off again so we need to get them up. [GHS #2] went into [client A's] room. [Client A] was mad that he had to get up and he was having a behavior. [GHS #2] bear hugged him and wouldn't let him go. [Client A] yelled stop. At that time, [GHS #5] told [GHS #2] to let [client A] go and [GHS #2] did." The investigation report indicated client A "ran" to the kitchen and "[GHS #2] then grabbed [client A] again and he started biting his hands. [GHS #5] told [GHS #2] again to let him go and when she did [client A] began falling toward the bathroom while [GHS #2] was still holding him."</p> <p>-GHS #5 indicated she "walked over in the middle of this incident and saw [GHS #2] holding [client A]. [GHS #5] told [GHS #2] to let him go and she did. [Client A] went in (the) kitchen and got some water. When he went back into the living room, [GHS #2] again grabbed him to get him into the hallway due to the sirens. At this time, he began hitting another consumer (unidentified client) in the head. [GHS #5] again told [GHS #2] to let [client A] go and she did. [GHS #2] was trying to make [client A] stay in the hallway."</p> <p>-GHS #2 indicated "she came in early because of the weather. She said the</p>			

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	<p>sirens were going off and she was helping get everyone up and in the hallway. She said [client A] went ballistic. He was biting himself and didn't want to sit so she helped him...He never sat in the hallway... [GHS #2] (indicated) [client A] threw himself into the bathroom. She stated that was how he got the scrapes because he fell into the bathtub. When asked if she put him in a bear hug, [GHS #2] stated no she did not. [GHS #2] (indicated) she tried to escort him to the hallway by holding his wrist and when he pulled away, she let him go. [GHS #2] stated that [GHS #5] never told her not to do what she was doing. [GHS #2] stated that it was an emergency situation and she was trying to make sure everyone was safe."</p> <p>Client A's record was reviewed on 9/26/13 at 8:25 AM. Client A's 9/10/13 ISP (Individual Support Plan) and 9/2013 Self Management Plan (SMP) both indicated client A was non verbal, had manic behavior, and required direct supervision by facility staff. Client A's SMP indicated client A's "Functional Analysis...I will become manic and begin spinning in circles and/or biting my hands. I will also run and scream through the home. I also become agitated and will act out as previously stated if I am asked to complete a task that I do not want to do (such as:) fire drills...I have become</p>						

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	<p>increasingly more difficult to redirect...C. Anxious or Manic: If I become anxious or manic I begin pacing, flicking my fingers, and/or become self abusive in the form of biting...To help prevent these occurrences staff should always inform me of where we are going, and what we will do when we get there. If I begin to behave manically, staff should tell me 'no' in a firm calm voice while signing No. If I am biting or scratching myself staff should intervene to stop the self abuse to prevent me from injuring myself. Then I should be redirected to another place...offer a new activity." Client A's SMP did not include physical restraints.</p> <p>On 10/1/13 at 1:15pm, an interview with the Director of Residential Services (DRS) was conducted. The DRS indicated facility staff failed to follow and failed to implement client A's ISP and SMP. The DRS indicated the facility staff failed to supervise client A according to his identified behavioral need. The DRS indicated the night of 6/12/13 had tornado sirens sounding on and off multiple times. The DRS indicated restraining clients during the tornado warning was not part of the tornado policy and procedure for what staff were to do in the event of an emergency. The DRS indicated facility staff had not been retrained on client A's</p>			
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	<p>ISP nor SMP since the incident.</p> <p>This federal tag relates to complaint #IN00131651.</p> <p>9-3-3(a)</p>				